

SUSPECTED INSURANCE FRAUD CITIZEN REPORTING FORM

State of West Virginia
Office of the Insurance Commissioner
Fraud Division
P.O. Box 50540
Charleston, WV 25305-0540
(304) 558-2100 ext. 133

Suspect

Name (First MI Last) _____ Telephone _____

Address _____ Date of Birth _____

City, State, Zip _____ Social Security _____

Prior Claims: ☐ Yes ☐ No Date of Loss _____

Involvement Insured ☐ 3rd Party ☐ Provider ☐ Claimant ☐ Witness ☐ Body Shop ☐
Non-Suspect Attorney ☐ Chiropractor ☐ Medical Doctor ☐ Law Enforcement ☐ Other ☐

Details of Suspected Fraud

Name (First MI Last) _____ Telephone _____

Address _____ E-mail _____

City, State, Zip _____

Signature _____